APPENDIX S-1

TECHNICAL GUIDELINES FOR CLAIM PREPARATION FORM DPA 2360, HEALTH INSURANCE CLAIM FORM

Please follow these guidelines in the preparation of claims for imaging processing to assure the most efficient processing by the Department:

- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script, or any font that has connecting characters.
- Claims should be typed or computer-printed in capital letters. The character pitch must be 10-12 printed character per inch, the size of most standard pica or elite typewriters. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photo-copying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachments with staples.

Appendix S-1a is a copy of Form DPA 2360, Provider Invoice. Instructions for completion of the Provider Invoice follow in the order entries appear on the form and addresses only those fields required by the Department. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required.
Optional	=	Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claim errors by the Department.
Conditionally Required	=	Entries which are required only under certain circumstances. Conditions of the requirement are identified in the instruction text.

COMPLETION		ITEM EXPLANATION AND INSTRUCTIONS
Required	**1.**	**Recipient Name** - Enter the participant's name exactly as it appears on the MediPlan Card or Temporary MediPlan Card or KidCare Card. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.
Conditionally Required	**2.**	**Birthdate** - Enter the month, day and year of birth of the participant as shown on the MediPlan Card or Temporary MediPlan Card or KidCare Card. An entry is required when charges are being billed when Form DPA 1411 does not contain a recipient number. Use the MMDDYY format.

Required **8. Recipient No.** - Enter the nine digit number assigned to the individual as copied from the MediPlan Card or Temporary MediPlan or KidCare Card. Use no punctuation or spaces. Do not use the Case Identification Number.

If the Temporary MediPlan Card does not contain the recipient number, enter the patient name and birthdate on the Provider Invoice and attach a copy of the Temporary MediPlan Card to the Provider Invoice. The Department will review the claim and determine the correct recipient number. See "Mailing Instructions" in this Appendix when a copy of the Temporary MediPlan Card is attached.

Conditionally Required **23a. Healthy Kids** - If a provider completed a heathly kids screening or if diagnostic and treatment services were provided because of a Healthy Kids screening, enter an “X” in the “YES” BOX.

Conditionally Required **23b. Family Planning** - If services were rendered for family planning purposes, enter an “X” in the “YES” box.

Required **23e. Type of Service** - Enter the code corresponding to the type of service for which the charges submitted on the claim apply.

Only one type of service can be included on a single claim. A separate claim must be prepared for each type of service for which charges are made. However, labs and x-rays do not have to be separated out. Use T.O.S. 1 and bill together.

The following codes are to be used.

1 - Medical Care - Attending Physician
2 - Surgery - Surgeon

Optional **23f. Diagnosis or Nature of Injury or Illness** - Enter the diagnosis or nature of injury or illness description which describes the condition primarily responsible for the patient’s treatment.

Optional **24. Repeat Code** - Usage not recommended.

Required **24a. Date of Service** - Enter the date the service was performed. (Use the MMDDYY format).

Required **24b. Place of Service** - Enter the appropriate code which identifies the place where the service was provided.

3 or 11 - Office/Clinic

Required **24c. Procedure Code/Drug Item Number** - When billing for services enter the appropriate five-digit CPT-4 or HCPCS procedure code.

When billing for dispensed items, enter the CPT-4 procedure code or eight-digit item number. Enter the name of the item dispensed in the description area (24C)

Required **24d. Primary Diagnosis** - Enter the specific ICD-9-CM code for the primary diagnosis. Do not use a decimal or leave a blank space in the decimal point's position.

Secondary Diagnosis: An entry in this field is optional. A second ICD-9-CM code may be entered to identify a secondary diagnosis when appropriate. Do not use a decimal or leave a blank space in the decimal point's position.

Required **24e. Provider Charges** - Enter the total charge for the service. Do not deduct any payment from a third party.

Conditionally Required **24f. Days/Units** - A four-digit entry is required only for the following:

- When billing for multiples of the same lab test, indicate the number; (e.g., for 2 lab tests, enter 0002)
- When billing for drug items dispensed, indicate the number; (e.g., for birth control pills, enter 0028).

Optional Delete - When an error has been made that cannot be corrected, enter an “X” to delete the entire service section. Only “X” will be a valid character, all other will be ignored.

Required **25. Signature of Physician and Date Signed -** The physician or authorized representative must sign the completed form in black or dark blue ink. Unsigned claims will be rejected. Only original signatures are accepted. Signatures must also be complete (no initials), legible and entered within the boundaries of this item. The signature should not overwrite the date field. Use MMDDYY format.

Required	**27.**	**Total Charge** - Enter the sum of all charges shown in service sections 1 through 7 of item 24E.
Required	**28.**	**Amount Paid** - Enter the total of all payments received from other sources. If no payment was received, enter 0.00. The entry must equal the sum of the amounts shown in fields 37C and 38C.
Required	**29.**	**Balance Due** - Enter the difference between the total charge and amount paid.
Required	**30.**	**Your Provider Number** - Enter the 12 digit provider number of the clinic exactly as it is shown on the Provider Information Sheet.
Required	**31.**	**Physician's or Supplier's Name, Address, Zip Code** - Enter the clinic's name exactly as it is shown on the Provider Information Sheet. When an address is entered, the Department will attempt to correct claims that have been suspended due to provider name/number errors. When no address is entered, the Department will not attempt to make corrections.
Conditionally Required	**32.**	**Patient's Account Number** - Providers may enter up to 10 characters used in your accounting system to identify the patient or transaction. This number will be included on your IDPA Remittance Advice.
Required	**33.**	**Payee Number** - Enter the single digit number of the payee to whom payment is to be sent. Payees are listed numerically on the Provider Information Sheet.
Required	**34.**	**Number of Sections** - Enter the total number of service sections in Item 24 which have been correctly completed.

Conditionally Required

37A. TPL Code - The TPL Code contained on the patient's MediPlan Eligibility Card (MEC) is to be entered in this field. If payment was received from a third party resource not listed on the MEC, enter the appropriate TPL Code as listed in Chapter 100, General Appendix 9. If none of the TPL codes that are listed in Chapter 100, General Appendix 9 are applicable to the source of payment, enter Code “999" and enter the name of the payment source in field 9, Other Health Insurance Coverage. If there is more than one source of other payments to report, the additional payments are to be shown in Sections 38A-D.

Spenddown - Refer to Chapter 100, Item 133 for a full explanation of Spenddown policy. If the client has a Spenddown obligation, they will either be responsible for the total amount of the charge or will present the provider with a Form DPA 2432 (SPLIT BILLING TRANSMITTAL FOR MANG SPENDDOWN PROGRAM). When a Form DPA 2432 is necessary, the Form DPA 2360 should be completed as follows:

If Form DPA 2432, Split Billing Transmittal, shows a recipient liability greater than $0.00 the invoice should be coded as follows:

37A; 906
37B; 01
37C; The actual recipient liability as shown on Form DPA 2432.
37D; The issuance date on the bottom right hand corner of the DPA 2432. This is in MMDDYY format.

If Form DPA 2432, Split Billing Transmittal, shows a recipient liability of $0.00 the invoice should be coded as follows:

37A; 906
37B; 04
37C; 0 00
37D; The issuance date on the bottom right hand corner of the DPA 2432. This is in MMDDYY format.

37B. TPL Status - A two-digit code indicating the disposition of the third party billing must be entered. The TPL Status Codes are:

01 - TPL Adjudicated - total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient or patient's third party resource. The amount of payment received must be entered in the TPL amount box.

02 - TPL Adjudicated - patient not covered: TPL Status 02 is to be entered when advised by the third party resource that the patient was not insured at the time goods or services were provided.

03 - TPL Adjudicated - service not covered: TPL Status Code 03 is to be entered when advised by the third party resource that goods or services provided are not covered.

04 - TPL Adjudicated - spenddown met: TPL Status Code 04 is to be entered when the patient's Form 2432, (Split Billing transmittal), shows $0.00 liability.

05 - Patient not covered: TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the Medical Eligibility Card is not in force.

06 - Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

07 - Third Party Adjudication Pending: TPL Status Code 07 may be entered when an invoice has been submitted to the third party and 30 days have elapsed since the third party was billed and reasonable follow-up efforts to obtain payment have failed.

10 - Deductible not met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

37C. TPL Amount - If there is no TPL amount, enter 0 00. Enter the amount of payment received from the third party resource. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box.

37D. TPL Date - A TPL date is required when any status code is shown in Item 37B. Use the following date for the specific TPL status codes;

01 = Third Party Adjudication Date or the date from the DPA 2432
02 = Third Party Adjudication Date
03 = Third Party Adjudication Date
04 = Date from DPA 2432
05 = Date of Service
06 = Date of Service
07 = Date of Service
10 = Third Party Adjudication Date

Conditionally Required

38A. (See 37A above)
38B. (See 37B above)
38C. (See 37C above)
38D. (See 37D above)

MAILING INSTRUCTIONS

The Provider Invoice is a two-part form. The provider is to submit the original to the Department as indicated below. The copy of the claim is to be retained by the provider.

The pin-feed guide strip should be detached from the sides of continuous feed forms.

Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, Form DPA 1444, Provider Invoice Envelope, provided by the Department.

Claims with attachments must be mailed to the Department in the pre-addressed mailing envelope, DPA 1414, Special Approval Envelope.

To order the envelopes mentioned in this topic, refer to Chapter 100, General Appendix 10.

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

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IDPA USE ONLY

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)

2. PATIENT'S DATE OF BIRTH | AGE

3. INSURED'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)

4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.:

5. PATIENT'S SEX

MALE ☐ FEMALE ☐

6. INSURED'S ID AND/OR MEDICARE NO. (INCLUDE ANY LETTERS)

7. PATIENT RELATION TO INSURED

SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. INSURED'S GROUP NO. (GROUP NAME) AND/OR MEDICAID NO.

9. OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER

10. WAS CONDITION RELATED TO

A. PATIENT'S EMPLOYMENT — YES ☐ NO ☐

B. ACCIDENT — AUTO ☐ OTHER ☐

11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)

SIGNED DATE

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW

SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOM: YES ☐ NO ☐ CHECK HERE IF EMERGENCY ☐

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY FROM THROUGH

DATES OF PARTIAL DISABILITY FROM THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY) | PROVIDER NUMBER

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES ☐ NO ☐ CHARGES:

23A. HEALTHY KIDS SERVICES YES ☐ NO ☐

23B. FAMILY PLANNING YES ☐ NO ☐

23C. STERILIZATION/ABORTION YES ☐ NO ☐

23D. PRIOR AUTHORIZATION NUMBER

23E. T.O.S. *

23F. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

24. REPEAT	A. DATE OF SERVICE	B. P.O.S. *	C. BRIEFLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY)	MOD	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	DELETE
1					PRIMARY			
2					SECONDARY			
3								
4								
5								
6								
7								

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (I AGREE TO COMPLY WITH THE REQUIREMENTS IN THE CERTIFICATION WHICH APPEARS ON THE REVERSE OF AND IS A PART OF THIS BILL)

SIGNED DATE

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY - SEE BACK) YES ☐ NO ☐

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. YOUR PROVIDER NUMBER

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE

32. YOUR PATIENT'S ACCOUNT NUMBER

33. YOUR PAYEE NUMBER

34. NUMBER OF SECTIONS

35. ORIGINAL DCN

36. ORIGINAL VOUCHER NUMBER

37A. TPL CODE	37B. TPL STATUS	37C. TPL AMOUNT	37D. TPL DATE	38A. TPL CODE	38B. TPL STATUS	38C. TPL AMOUNT	38D. TPL DATE

* PLACE OF SERVICE (P.O.S.) AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS:

Completion mandatory, Ill. Rev. Stat., Ch. 23, P.A. Code, penalty non-payment

Form Approved by the Forms Management Center

IL 478-1032
Form HCFA 1500
ILLINOIS DPA 2360 (R-2-90)